Behavioural and Cognitive Psychotherapy, 2004, 32, 199–213
Printed in the United Kingdom DOI: 10.1017/S135246580400116X

FACTORS THAT CONSTITUTE A GOOD COGNITIVE BEHAVIOURAL TREATMENT MANUAL: A DELPHI STUDY

Edward A. S. Duncan

The State Hospital, Carstairs, Lanark, Scotland

Margaret M. Nicol and Alastair Ager

Queen Margaret University College, Edinburgh, Scotland

Abstract. Cognitive behavioural treatment manuals have increased in frequency, purpose and impact over the last 40 years. Despite numerous papers on the topic, few empirical studies regarding the constitution of treatment manuals have been conducted. A Delphi study examining the factors that constitute a good cognitive behavioural treatment manual is presented. This study generated a consensus of opinion of factors that therapists and researchers should consider when developing and appraising treatment manuals for cognitive behavioural interventions. Limitations of the study and the potential relevance of the research are discussed.

Keywords: Treatment manual, Delphi study, consensus, factors.

Introduction

Treatment manuals have existed since the 1960s (Wolpe, 1969). However, the last 25 years have witnessed a particular growth in their use and expansion in purpose. Since 1984, treatment manuals have become viewed as a "virtual requirement" for all psychotherapy research, a shift that was seen as a revolution in psychotherapy research style (Luborsky & DeRubeis, 1984). By the mid 1990s, treatment manuals were viewed not only as vital within psychotherapy research, but also as offering important advantages for clinical practice (Wilson, 1996). These developments have resulted in such interventions being, "... both celebrated and vilified in the literature" (Kendall, Chu, Gifford, Hayes, & Nauta, 1998). This debate has unfolded in numerous articles either defending or denigrating the use of treatment manuals.

Themes arising from the literature

Fundamentally two perspectives are maintained: the position that views case formulation and goal setting as core tenets of practice, and a growing alternative perspective that views treatment manuals as evidence-based interventions that ensure all users have equitable access to effective practice. These issues have been comprehensively discussed within the

Reprint requests to Edward A. S. Duncan, Senior Occupational Therapist, Resource Centre, The State Hospital Carstairs, Lanark ML11 8RP, Scotland. E-mail: eddie.duncan@tsh.scot.nhs.uk

literature. Supporters of treatment manuals focus on their ability to assist in the development of treatment efficacy and their value in research and education. Perhaps the greatest strength of treatment manuals has been their use within research and education, where they allow for the objective comparison of interventions, assist in the training and supervision of therapists and in the development of audit programmes to ensure treatment integrity (Carroll & Nuro, 2002; Wilson, 1998). Treatment manuals, however, are not without their critics.

Manuals have been criticized for limiting the range of therapeutic options available to a client, not meeting the needs of individuals with multifaceted problems and therefore potentially being clinically harmful (Addis, Wade, & Hatgis, 1999; Henry, 1998; Mansfield & Addis, 2001a, b). One of the central criticisms of treatment manuals is that they restrict the clinical artistry of the therapist, thereby turning therapists into technicians (Barron, 1995; Henry, 1998). Such restrictions are believed to limit the expertise of therapists, may lower job satisfaction and negatively affect the development of an individual as a therapist (Abrahamson, 1999; Addis et al., 1999; Castonguay, Schut, Constantino, & Halperin, 1999). Other criticisms of treatment manuals include the increased expense of having to purchase them, issues surrounding competence to practise using manuals, and the over adherence to one therapeutic perspective (Addis & Krasnow, 2000; Dobson & Shaw, 1988). Dobson and Shaw (1988), summarize these issues stating that, in their view, treatment manuals are conceptually at odds with cognitive behavioural therapy. Such criticisms have, however, been strongly rebutted in the literature (Heimberg, 1998; Marques, 1998; Wilson, 1998; Woody, 2000).

Content of treatment manuals

Despite considerable debate surrounding the validity of cognitive behavioural treatment manuals, no consensus has been reached regarding their constitution. Manuals currently in existence are neither equivalent in shape nor form and a wide range exists in levels of specificity, structure and standardization (Dobson & Shaw, 1988; Lambert, 1998).

Addis and Krasnow (2000) and Najavits, Weiss, Shaw and Dierberger (2000) carried out empirical studies examining attitudes of practising psychologists towards treatment manuals. Addis and Krasnow (2000) surveyed practising psychologists in America. Participants ($n = 891$) reported varying attitudes towards treatment manuals. Unsurprisingly, such differences in opinion reflected their perspective of treatment manuals. Negative attitudes amongst participants correlated with a belief that manuals are technique focused and less likely to emphasize the importance of the therapeutic relationship (Addis & Krasnow, 2000). As this study was not restricted to therapists with expertise in cognitive behavioural therapy, the findings were confounded by participants from differing frames of reference. Contemporaneously, Najavits et al. (2000) published a similar survey. This smaller study ($n = 47$) gathered data from a convenience sample of cognitive behavioural therapists attending a national American conference. Participants were requested to rate 20 pre-selected components of an "ideal manual". The article does not state how these items were selected. In contrast to Addis and Krasnow (2000), the findings of Najavits et al. (2000) highlighted a positive response to treatment manuals: 75% stated they liked manuals "a lot" or "a great deal". Najavits et al. (2000) suggest that manuals should be selected for use if they, " . . . offer some empirical support, more extensive features, realistic and practical advice on what to do

when treatment does not go as planned, and a strong theoretical rationale" (p. 407). Whilst the findings of this study are not subjected to the confounding variables found in Addis and Krasnow (2000), the study is biased by its sampling methods and use of a predefined list of components.

Treatment manuals have considerably impacted upon methods of cognitive behavioural intervention. Despite concern regarding their epistemological basis, treatment manuals appear firmly rooted in current practice and are unlikely to diminish. Whilst there has been extensive discussion of the role and place of treatment manuals, little study of their construction has taken place. Such information would be valuable in the development and evaluation of treatment manuals in this area.

Method

Delphi methodology

The study explored factors that were viewed as "essential", "desirable" and "inappropriate" in the development of cognitive behavioural treatment manuals. Delphi methodology was employed, as it has been recognized as an appropriate method for developing consensus among experts (Murphy et al., 1998). Furthermore, the geographical dispersion of the participants meant that an electronic Delphi study provided an efficient method for gathering data and communication between the participants and the researcher (Shannon, Johnson, Searcy, & Lott, 2001).

The specific type of Delphi study conducted was a combination of both policy and numeric design, as both narrative and numeric data were solicited from participants (Strauss & Ziegler, 1975). Data collection was restricted to three rounds, as this has been shown to be most effective (Sumison, 1998). In line with traditional Delphi methodology, the first round was left as an open question, lessening the bias recognized in other formats.

Participants

The study employed a purposive sampling process. Experts were strictly defined as individuals who have published treatment manuals or used them in published research. Potential participants were gathered through an electronic search of Cinhal and PsychInfo using the terms "treatment manual" or "protocol driven therapy" and (Cognitive Behav* *Therapy" or "CBT" or "Cognitive Therapy or Behav* *therapy") for the years 1990–2002. The Cochrane database was also screened using the same search terms and time period. Authors of published treatment manuals not generated using this search strategy, but known to the first author, were also included in the original sample. Only English language articles were included.

As the Delphi study was electronic, searches for e-mail addresses were carried out on all identified primary authors ($n = 35$). This approach to survey methodology is recognized as valid and has the advantage of gaining fast responses, requires little technological expertise and eases the financial burden of postage and the time consuming nature of carrying out international research (Shannon et al., 2001). E-mail addresses were ascertained for all but six participants ($n = 29$).

Ethical considerations

Prospective participants ($n = 29$) were e-mailed a pre-notification letter inviting them to participate in the study. Individuals wishing to participate were requested to reply to the e-mail. A positive response was viewed as informed consent. The e-mail process enabled the mass mailing of all correspondence without individuals' knowledge of each other, a key component of the Delphi process.

Protocol

Round 1. An e-mail, with attachment, was sent to the consenting sample. In the attachment, participants were asked to list, "... what [they] believe should be the contents of a 'good' [cognitive behavioural therapy] treatment manual". Three reminder e-mails were sent out in this and subsequent rounds at regular intervals to non-respondents.

Round 2. Items generated from round 1 were thematically analysed by the researcher and a colleague experienced in using treatment manuals. Where initial disagreement regarding categorization of items arose, discussion took place and an agreement was reached. Where more than one item clearly described the same factor, only one item was included in round 2. Some items could have been placed in more than one category and where this occurred the researcher and his colleague made a judgment regarding where they felt each item best lay. Following analysis, a questionnaire was designed for the subsequent rounds. In order to facilitate completion, a 3-point ordinal rating scale for each item was generated as follows:

E = Essential – Each manual must contain this item;
D = Desirable – Inclusion of this item enhances the manual;
I = Inappropriate – Not applicable to the manual.

Round 3. The results of round two were collated and the percentage agreement for each category was placed next to each item. The returned questionnaire included the participants' original responses and participants were given the opportunity to amend their selection (if desired) in response to viewing the overall feedback of the group.

Consensus

As there is no agreement concerning the required degree of consensus in a Delphi study, it was decided to set consensus levels at two-thirds of the responses. This cut-off point is viewed as a compromise position between the 50% consensus supported by Loughlin and Moore (1979) and the 100% cut off suggested by Williams and Webb (1994).

Findings

Agreement to participate

Nine of the participants' addresses were rejected as "undeliverable" by the e-mail system and working e-mail addresses were not discovered. Two individuals responded to the pre-notification letter but then declined to participate due to work commitments. A further 14

individuals responded and agreed to participate in the study. Four potential participants did not respond to the initial request and subsequent reminder messages.

Round 1. Ten responses were received in round 1. Four participants, who had originally consented to partake in the study, did not reply to the first round questionnaire, or subsequent e-mail reminders. The expert panel was equally split by gender, was predominated by psychologists ($n = 7$), although participants also included individuals from a psychiatric ($n = 2$) and nursing ($n = 1$) backgrounds. The majority of participants lived in the United Kingdom ($n = 6$), with others living in the United States of America ($n = 1$), Canada ($n = 2$) and Australasia ($n = 1$). One hundred and fifteen items considered by participants to form a good treatment manual were returned. The mean number of items returned per participant was 11.5 [Range = 7–18]. Following thematic analysis, a final list of 79 items existed.

Round 2. Nine responses were returned to the researcher in round two. Consensus was gained on 52 Items. Seventeen items gained consensus as essential to the development of a good cognitive behavioural therapy treatment manual and 35 items were viewed as desirable. No items were consensually viewed as inappropriate. Twenty-seven items did not achieve consensus in round two.

Round 3. Nine responses were returned in round three of the study. Consensus was gained on 53 items. Changes occurred in both directions. Twenty-one items gained consensus as essential to the development of a good cognitive behavioural therapy treatment manual (an increase of three items from round two). Thirty-two items gained consensus as desirable to the development of a good cognitive behavioural therapy treatment manual (a decrease of three items from round two). Changes, to levels of consensus, occurred in both directions. As in round two, no items were consensually viewed as inappropriate. Twenty-six items did not reach agreed level of consensus (see Table 1).

Summary of findings

This study generated, categorized and ranked 79 items of "... factors that comprise the contents of a 'good' cognitive behavioural treatment manual". Each item was analysed and placed into one of 10 categories:

- General characteristics: 18 items. Consensus gained in 72% of items
- Pre-group information: 3 items. No consensus gained on any item
- General information: 19 items. Consensus gained in 79% of items
- Outcome measures/assessment information: 5 items. Consensus gained in 100% of items
- Intervention strategies/chapter: 10 items. Consensus gained in 70% of items
- Physical presentation of treatment manual: 4 items. Consensus gained in 75% of items
- Relapse prevention: 1 item. No consensus gained
- Specific content of patient led treatment manual: 8 items. Consensus gained in 63% of items
- Physical presentation of patient treatment manual: 6 items. Consensus gained in 67% of items
- Therapeutic relationship issues: 5 items. Consensus gained in 20% of items

Table 1. Round 3 consensus ranked according to strength of agreement

No	Item	Essential % round 2/3	Desirable % round 2/3	Inappropriate % round 2/3	Missing data % round 2/3
	General characteristics of treatment manuals				
	Essential characteristics				
1	Appropriate for the problem addressed	100	0	0	0
2	The manual should be coherent and focused	88.9/100	11.1/0	0	0
3	Should provide illustrations of points in text, where point is obtuse	55.6/77.8	44.4/22.2	0	0
4	Should offer the client a chance to opt out if not improving without feeling like a failure	66.7	33.3	0	0
5	Based on clear theoretical model	66.7	33.3	0	0
	Desirable characteristics				
6	Should not undermine therapist style	11.1	77.8/88.9	11.1/0	0
7	Able to be utilized by a wide range of therapists	11.1	88.9	0	0
8	Chapters can be given independently	11.1	88.9	0	0
9	Manuals should tackle co-morbidity rather than focus on one specific disorder	11.1	77.8	11.1	0
10	Comprehensive	11.1	77.8	0	11.1
11	Programmes should be integrated by themes and logically progress	22.2	77.8	0	0
12	The manual has had user input in its development	22.2/33.3	77.8/66.7	0	0
13	Not over prescriptive	22.2/33.3	77.8/66.7	0	0
	Important issues to consider				
14	Sessions should be linked in some sensible way	55.6	44.4	0	0
15	Specific for the problem and person using it	44.4	55.6	0	0
16	Whole programme should be integrated by themes	44.4/55.6	55.6/44.4	0	0
17	Not too long	33.3/44.4	55.6/44.4	11.1	0
18	Should provide a client centred approach	33.3/44.4	44.4/33.3	22.2	0
	Pre-group information that should be found in treatment manuals				
	Important issues to consider				
19	Selection criteria for suitable clients should be included in the manual	44.4	44.4	11.1	0
20	Methods for assessing referral to identify suitable participants	22.2	55.6	22.2	0
21	Background and procedural information for clients	33.3	55.6	11.1	0

Table 1. (cont.)

No	Item	Essential % round 2/3	Desirable % round 2/3	Inappropriate % round 2/3	Missing data % round 2/3
	General information that should be found in treatment manuals				
	Essential characteristics				
22	A clear specification of what the intervention aims to do	88.9	11.1	0	0
23	A statement of the aims and objectives of each session	77.8/88.9	22.2/11.1	0	0
24	A detailed description of the problem for which the manual has been designed	77.8	22.2	0	0
25	Detailed description of the conceptual ideas that are the basis for treatment	77.8	22.2	0	0
26	A clear specification of who can utilize the manual (i.e. training and experience)	55.6/66.7	44.4/33.3	0	0
27	Instructions to therapists on how to present content	66.7	33.	0	0
28	A theoretical rationale for the treatment	55.6/66.7	44.4/33.3	0	0
	Desirable characteristics				
29	Expected treatment course: A description of how to maximally apply therapy	0	100	0	0
30	Evidence that the manual has been rigorously evaluated/treatment outcome research	11.1	88.9	0	0
31	Evaluated on representative population – not volunteers to cognitive therapy centres	11.1	88.9	0	0
32	Evidence of the efficacy of the manual in general	22.2/11.1	66.7/77.8	0	11.1
33	Expected treatment outcomes and common variations	33.3/22.2	66.7/77.8	0	0
34	Establish the credentials of the authors	33.3/22.2	66.7/77.8	0	0
35	An indication of the degree of rigidity/flexibility of the manual	33.3/22.2	66.7/77.8	0	0
36	Evidence that it has been developed with client input and feedback	22.2/33.3	77.8/66.7	0	0
	Important issues to consider				
37	Uncomplicated interventions	44.4/55.6	44.4/33.3	11.1	0
38	An idea of the style of intervention – how the material is to be put across	55.6/44.4	44.4/55.6	0	0
39	Flexibility – Pt. and therapist should be able to modify/omit/add to programme easily	33.3	55.6	11.1	0
40	A description of proscribed interventions	33.3	44.4/33.3	22.2/33.3	0

Table 1. (cont.)

No	Item	Essential % round 2/3	Desirable % round 2/3	Inappropriate % round 2/3	Missing data % round 2/3
	Outcome measures/assessment information				
	Desirable characteristics				
41	Information on how to acquire assessment tools	22.2/11.1	77.8/88.9	0	0
42	Scoring for the measurement tools should be included	33.3/22.2	66.7/77.8	0	0
43	Information on how to feedback assessment information to participants	33.3/22.2	66.7/77.8	0	0
44	Assessment methods should be illustrated with case examples	33.3/22.2	55.6/66.7	11.1	0
45	There should be enough information that a psychotherapy researcher can use the manual to develop treatment fidelity measures (for both adherence and competence)	33.3	66.7	0	0
	Intervention strategies/chapters				
	Essential characteristics				
46	Rationale of therapy should be linked to intervention	100	0	0	0
47	Treatment procedures should be detailed	88.9	11.1	0	0
	Desirable characteristics				
48	Treatment manuals should state when to employ adjunctive treatment approaches	22.2/11.1	77.8/88.9	0	0
49	Provide evidence for suggested strategies	11.1	77.8	11.1	0
50	Common variations in interventions should be described	11.1	77.8	11.1	0
51	Treatment procedures should be illustrated with realistic clinical case examples	33.3/22.2	55.6/66.7	11.1	0
52	Offer information about medication	11.1/22.2	66.7	22.2/11.1	0
	Important issues to consider				
53	Treatment manuals should provide information on how to link interventions with other people (e.g. partner, family) and issues (jobs, accommodation) in a person's life	44.4	55.6	0	0
54	Treatment manuals should provide several alternative intervention strategies	11.1	55.6	33.3	0
55	Uncomplicated interventions should be utilized	44.4	55.6	0	0

Table 1. (cont.)

No	Item	Essential % round 2/3	Desirable % round 2/3	Inappropriate % round 2/3	Missing data % round 2/3
	Physical presentation of treatment manual				
	Desirable characteristics				
56	Handouts and visual materials should be included	11.1/22.2	88.9/77.8	0	0
57	Master copies of any record keeping materials	11.1	88.9	0	0
58	Photocopyable materials	11.1	77.8	11.1	0
	Important issues to consider				
59	Guidelines as to resources needed for the programme	33.3/44.4	66.7/55.6	0	0
	Relapse prevention				
	Important issues to consider				
60	Should provide information on relapse prevention	44.4	55.6	0	0
	Specific content of patient led treatment manuals				
	Essential characteristics				
61	User friendly	100	0	0	0
62	Gives hope that therapy will work	66.7/77.8	33.3/22.2	0	0
63	Positive encouraging tone to increase motivation	66.7/77.8	33.3/22.2	0	0
64	Subject to plain English/FLESCH ratings	66.7/77.8	33.3/22.2	0	0
65	Provide simple fun quizzes	55.6/66.7	44.4/33.3	0	0
	Important issues to consider				
66	Requires questions to be answered	33.3/44.4	66.7/55.6	0	0
67	Reduces the need to rely on the therapist	33.3/44.4	66.7/55.6	0	0
68	Has space to write and personalize manual	44.4/55.6	55.6/44.4	0	0
	Physical presentation of patient treatment manual				
	Essential characteristics				
69	Clearly written	100	0	0	0
70	Well presented	100	0	0	0
	Desirable characteristics				
71	Large type	22.2/33.3	77.8/66.7	0	0
72	Plenty clear space	11.1/22.2	66.7	11.1/0	11.1

Table 1. (cont.)

No	Item	Essential % round 2/3	Desirable % round 2/3	Inappropriate % round 2/3	Missing data % round 2/3
	Important issues to consider				
73	Should contain a good index	33.3/22.2	55.6	11.1/22.2	0
74	Many illustrations and vignettes	22.2/33.3	66.7/55.6	0	11.1
	Therapeutic relationship issues				
	Desirable characteristics				
75	A description of the ideal type of therapeutic relationship, how the therapist can help develop this therapeutic relationship and any changes that might be expected over the course of treatment	33.3	66.7	0	0
	Important issues to consider				
76	Information about how to handle ruptures in the therapeutic alliance	33.3	55.6	11.1	0
77	Should include a section on end of therapy issues (expected termination, interpersonal issues, session scheduling variations. . .)	33.3/44.4	55.6/44.4	11.1	0
78	Should include information on common stuck points and roadblocks in treatment with recommended strategies for dealing with these	33.3/55.6	66.7/44.4	0	0
79	Hints to therapists on how to deal with non standard responses from clients	44.4/55.6	33.3	22.2/11.1	0

Essential characteristics of treatment manuals

Only 21 (27%) of the generated items were rated as essential. These items fell within five dimensions and were:

- General characteristics of treatment manuals
  - Appropriate for the problem addressed
  - The manual should be coherent and focused
  - Should provide illustrations of points in text where point is obtuse
  - Should offer the client a chance to opt out if not improving without feeling like a failure
  - Based on a clear theoretical model
- General information that should be found in treatment manuals
  - A clear specification of what the intervention aims to do
  - A statement of the aims and objectives of each session
  - A detailed description of the problem for which the manual has been designed
  - A detailed description of the conceptual ideas that are the basis for treatment
  - A clear specification of who can utilize the manuals (i.e. training and experience)
  - Instructions to therapists on how to present content
  - A theoretical rationale for treatment
- Intervention strategies/chapters
  - Rationale of therapy should be linked to intervention
  - Treatment procedures should be detailed
  - Treatment procedures should be illustrated with realistic clinical case examples
- Specific content of patient led treatment manuals
  - User friendly
  - Give hope that therapy will work
  - Positive encouraging tone to increase motivation
  - Subject to plain English/FLESCH ratings
- Physical presentation of patient led treatment manual
  - Clearly written
  - Well presented

Desirable characteristics of treatment manuals

Thirty-two items generated within the study (41%) were considered to be desirable characteristics of treatment manuals. Due to limitations of space, desirable items are listed in Table 1 and are not repeated here.

Important issues to consider

Twenty-six items (33%) failed to reach consensus as participants were split as to whether these items were essential or desirable. Whilst consensus was not reached in this respect, the importance of these items was highlighted and they have been included under the heading important issues to consider in order that they are not overlooked. Items falling within the category of important issues to consider are also listed in Table 1. Importantly, no items reached a consensus as inappropriate for inclusion within a treatment manual.

Discussion

The use of an exploratory Delphi study in this area is novel and the method lent itself to accessing an international sample of experts who were geographically dispersed (Murphy et al., 1998). This methodology has limitations, however, and their potential impact on the rigour of the study is discussed below.

Purposive sampling is appropriate for exploratory research such as Delphi methodology (Salant & Dillman, 1994). The careful selection of "expert" participants has been defined as fundamental to the credibility of a consensus panel (Fink, Kosecoff, Chassin, & Brook, 1984). Too narrow a definition, however, can restrict the number of potential participants. Within this study, experts were strictly defined as individuals who have published treatment manuals or used them in published research. Whilst such a clear definition enhances the credibility and acceptance of the findings of Fink et al. (1984), it also resulted in a small number of individuals from whom to recruit ($n = 35$).

Poor recruitment and retention of participants significantly impacts on the credibility of research findings. From an initial pool of 35 individuals, only 9 (26%) subsequently completed the three rounds of the study. The reasons for this low response were various and included lack of availability of correct e-mail addresses ($n = 15$), refusal to participate ($n = 2$) and non response ($n = 4$). Fourteen individuals consented to participate; however, despite reminders, only 10 participants responded to round one, whilst a further one dropped out in round two. Non-respondent bias has been noted to be one of the main disadvantages of the Delphi approach (Cantrill, Sibbald, & Buetow, 1996). As ultimately only 26% of the potential population participated in the study, it is important to consider that the findings may be unrepresentative.

Ordinal ranking of items has previously been used within Delphi studies (Claxton, Ritchie, & Zaichkowsky, 1980). This study used a 3-point ordinal scale. The advantage of such a scale was that it provided a clear method for ranking items, which could then be easily transposed into a meaningful guideline for therapists and researchers engaged in the design and appraisal of CBT treatment manuals. Likert scales are, however, more commonly used in Delphi research as they allow for greater sensitivity in data analysis and meaningful reportage of both central tendencies and levels of dispersion (Love, 1997; Hasson, Keeney, & McKenna, 2000).

At the end of the third round, 26 items still lacked consensus. Whether this is due to the small sample size or divergence of clinical opinion is impossible to state. The greatest degree of split on the items lacking consensus is between desirable and essential. Such a split suggests that each item is an important item to consider; however, there is a lack of agreement surrounding the degree of importance.

This study has provided the first grounded definition of factors that should be included within a cognitive behavioural treatment manual. Delphi methodology can be used both to generate new information and to confirm existing data. This study has accomplished both. Comparing the findings of Najavits et al. (2000) with the findings from this study, it is observable that the majority of the Najavits et al. (2000) items (80%, $n = 16$) were also generated within the Delphi study. The current study also contained a further 63 items that were not originally listed by Najavits et al. (2000). However, five specific items in that study were not generated in the current study:

- Bibliography for further reading
- Transcripts of patients-therapist dialogue

- An adherence scale that specifies how to rate a therapist for how well she or he complies with the manual
- A videotape to accompany the manual, demonstrating actual in session techniques and procedures
- A self quiz to test the therapist's knowledge of the material

This study is the first to explore treatment manuals using a recognized consensus development methodology on a clearly defined "expert" sample. Whilst the existence of a consensus does not mean that the correct answer has been discovered, the reliability of the items gathered in the study is supported by a close correlation with the items generated in Najavits et al. (2000). Najavits et al. (2000) concluded that their findings could be summarized in two principles:

- The importance of practical advice
- The notion that more is better

These principles are supported by the findings of this study. Fifteen items gained consensus as being essential to treatment manual development and six items gained consensus essential to the content of patient led treatment manuals. Several of these items focus on the importance of practical advice. Najavits et al. (2000) further state that, " . . . the principle that more is better is indicated by therapists having endorsed each component positively: none were rejected as being unhelpful" (p. 406). Within this study, no item was consensually viewed as inappropriate, thus supporting the second principle of Najavits et al. (2000).

This study did not aim to further the debate regarding the place of treatment manuals within cognitive behavioural therapy. Instead, it aimed to clarify the content of such manuals. Participants in this study were selected for their expertise in the design or use of treatment manuals. The findings of the study reflect the biases that may be assumed within this population. Therapists who conceptually disagree with the developments of treatment manuals are therefore unlikely to be persuaded by the findings of this study. Instead, it is probable that they will highlight the omission of individual case formulations from the findings as supporting evidence that treatment manuals do not reflect best practice within cognitive behavioural therapy.

The importance of an empirical basis to therapeutic interventions is clearly documented in the literature on treatment manuals (Chambless & Hollon, 1998; Fonagy, 1999; Messer, 2001; Norcross, 1999; Sanderson & Woody, 1995). Interestingly, items related to the requirement of an empirical basis for treatment manuals (Table 1 items 30–32) gained consensus as desirable. Such a response was unexpected, as a non-empirically supported treatment manual could be viewed as offering little benefit to a therapist's intervention (Norcross, 1999). Flexibility is another theme that frequently occurs within the literature. In line with Addis et al. (1999) and Wilson (1996), the findings endorsed three items that emphasized the importance of integrating flexibility within a treatment manual:

- Not over prescriptive
- An indication of the degree of rigidity/flexibility of the manual
- Flexibility – patient and therapist should be able to modify/omit/add to programme easily

Interestingly, however, none of these items obtained classification as an essential treatment manual characteristic within this study.

The limitations of this study, in particular the small sample size, restrict the potential transferability of the findings. The study does, however, contribute further towards an understanding of the factors that constitute a good cognitive behavioural treatment manual. As such, both therapists and researchers may find this study beneficial in the future design and appraisal of cognitive behavioural treatment manuals. The findings of this study are therefore offered as a further development to the literature on treatment manuals and as a basis for future research.

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